HB 1652 - S COMM AMD
By Committee on Health Care

ADOPTED 4/3/2015

1 Strike everything after the enacting clause and insert the
2 following:

3 "**Sec. 1.** RCW 74.09.522 and 2014 c 225 s 55 are each amended to
4 read as follows:
5 (1) For the purposes of this section:
6 (a) "Managed health care system" means any health care
7 organization, including health care providers, insurers, health care
8 service contractors, health maintenance organizations, health
9 insuring organizations, or any combination thereof, that provides
10 directly or by contract health care services covered under this
11 chapter and rendered by licensed providers, on a prepaid capitated
12 basis and that meets the requirements of section 1903(m)(1)(A) of
13 Title XIX of the federal social security act or federal demonstration
14 waivers granted under section 1115(a) of Title XI of the federal
15 social security act;
16 (b) "Nonparticipating provider" means a person, health care
17 provider, practitioner, facility, or entity, acting within their
18 scope of practice, that does not have a written contract to
19 participate in a managed health care system's provider network, but
20 provides health care services to enrollees of programs authorized
21 under this chapter whose health care services are provided by the
22 managed health care system.
23 (2) The authority shall enter into agreements with managed health
24 care systems to provide health care services to recipients of
25 temporary assistance for needy families under the following
26 conditions:
27 (a) Agreements shall be made for at least thirty thousand
28 recipients statewide;
29 (b) Agreements in at least one county shall include enrollment of
30 all recipients of temporary assistance for needy families;
31 (c) To the extent that this provision is consistent with section
32 1903(m) of Title XIX of the federal social security act or federal
33 demonstration waivers granted under section 1115(a) of Title XI of

the federal social security act, recipients shall have a choice of systems in which to enroll and shall have the right to terminate their enrollment in a system: PROVIDED, That the authority may limit recipient termination of enrollment without cause to the first month of a period of enrollment, which period shall not exceed twelve months: AND PROVIDED FURTHER, That the authority shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the authority by rule;

(d) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act, participating managed health care systems shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems, except as authorized by the authority under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(e)(i) In negotiating with managed health care systems the authority shall adopt a uniform procedure to enter into contractual arrangements, to be included in contracts issued or renewed on or after January 1, 2015, including:

(A) Standards regarding the quality of services to be provided;

(B) The financial integrity of the responding system;

(C) Provider reimbursement methods that incentivize chronic care management within health homes, including comprehensive medication management services for patients with multiple chronic conditions consistent with the findings and goals established in RCW 74.09.5223;

(D) Provider reimbursement methods that reward health homes that, by using chronic care management, reduce emergency department and inpatient use;

(E) Promoting provider participation in the program of training and technical assistance regarding care of people with chronic conditions described in RCW 43.70.533, including allocation of funds to support provider participation in the training, unless the managed care system is an integrated health delivery system that has programs in place for chronic care management;

(F) Provider reimbursement methods within the medical billing processes that incentivize pharmacists or other qualified providers licensed in Washington state to provide comprehensive medication management services consistent with the findings and goals established in RCW 74.09.5223;

1 (G) Evaluation and reporting on the impact of comprehensive
2 medication management services on patient clinical outcomes and total
3 health care costs, including reductions in emergency department
4 utilization, hospitalization, and drug costs; and
5 (H) Established consistent processes to incentivize integration
6 of behavioral health services in the primary care setting, promoting
7 care that is integrated, collaborative, colocated, and preventive.
8 (ii)(A) Health home services contracted for under this subsection
9 may be prioritized to enrollees with complex, high cost, or multiple
10 chronic conditions.
11 (B) Contracts that include the items in (e)(i)(C) through (G) of
12 this subsection must not exceed the rates that would be paid in the
13 absence of these provisions;
14 (f) The authority shall seek waivers from federal requirements as
15 necessary to implement this chapter;
16 (g) The authority shall, wherever possible, enter into prepaid
17 capitation contracts that include inpatient care. However, if this is
18 not possible or feasible, the authority may enter into prepaid
19 capitation contracts that do not include inpatient care;
20 (h) The authority shall define those circumstances under which a
21 managed health care system is responsible for out-of-plan services
22 and assure that recipients shall not be charged for such services;
23 (i) Nothing in this section prevents the authority from entering
24 into similar agreements for other groups of people eligible to
25 receive services under this chapter; and
26 (j) The authority must consult with the federal center for
27 medicare and medicaid innovation and seek funding opportunities to
28 support health homes.
29 (3) The authority shall ensure that publicly supported community
30 health centers and providers in rural areas, who show serious intent
31 and apparent capability to participate as managed health care systems
32 are seriously considered as contractors. The authority shall
33 coordinate its managed care activities with activities under chapter
34 70.47 RCW.
35 (4) The authority shall work jointly with the state of Oregon and
36 other states in this geographical region in order to develop
37 recommendations to be presented to the appropriate federal agencies
38 and the United States congress for improving health care of the poor,
39 while controlling related costs.

1 (5) The legislature finds that competition in the managed health
2 care marketplace is enhanced, in the long term, by the existence of a
3 large number of managed health care system options for medicaid
4 clients. In a managed care delivery system, whose goal is to focus on
5 prevention, primary care, and improved enrollee health status,
6 continuity in care relationships is of substantial importance, and
7 disruption to clients and health care providers should be minimized.
8 To help ensure these goals are met, the following principles shall
9 guide the authority in its healthy options managed health care
10 purchasing efforts:

11 (a) All managed health care systems should have an opportunity to
12 contract with the authority to the extent that minimum contracting
13 requirements defined by the authority are met, at payment rates that
14 enable the authority to operate as far below appropriated spending
15 levels as possible, consistent with the principles established in
16 this section.

17 (b) Managed health care systems should compete for the award of
18 contracts and assignment of medicaid beneficiaries who do not
19 voluntarily select a contracting system, based upon:

20 (i) Demonstrated commitment to or experience in serving low-
21 income populations;

22 (ii) Quality of services provided to enrollees;

23 (iii) Accessibility, including appropriate utilization, of
24 services offered to enrollees;

25 (iv) Demonstrated capability to perform contracted services,
26 including ability to supply an adequate provider network;

27 (v) Payment rates; and

28 (vi) The ability to meet other specifically defined contract
29 requirements established by the authority, including consideration of
30 past and current performance and participation in other state or
31 federal health programs as a contractor.

32 (c) Consideration should be given to using multiple year
33 contracting periods.

34 (d) Quality, accessibility, and demonstrated commitment to
35 serving low-income populations shall be given significant weight in
36 the contracting, evaluation, and assignment process.

37 (e) All contractors that are regulated health carriers must meet
38 state minimum net worth requirements as defined in applicable state
39 laws. The authority shall adopt rules establishing the minimum net
40 worth requirements for contractors that are not regulated health

1 carriers. This subsection does not limit the authority of the
2 Washington state health care authority to take action under a
3 contract upon finding that a contractor's financial status seriously
4 jeopardizes the contractor's ability to meet its contract
5 obligations.

6 (f) Procedures for resolution of disputes between the authority
7 and contract bidders or the authority and contracting carriers
8 related to the award of, or failure to award, a managed care contract
9 must be clearly set out in the procurement document.

10 (6) The authority may apply the principles set forth in
11 subsection (5) of this section to its managed health care purchasing
12 efforts on behalf of clients receiving supplemental security income
13 benefits to the extent appropriate.

14 (7) By April 1, 2016, any contract with a managed health care
15 system to provide services to medical assistance enrollees shall
16 require that managed health care systems offer contracts to
17 behavioral health organizations, mental health providers, or chemical
18 dependency treatment providers to provide access to primary care
19 services integrated into behavioral health clinical settings, for
20 individuals with behavioral health and medical comorbidities.

21 (8) Managed health care system contracts effective on or after
22 April 1, 2016, shall serve geographic areas that correspond to the
23 regional service areas established in RCW 43.20A.893.

24 (9) A managed health care system shall pay a nonparticipating
25 provider that provides a service covered under this chapter to the
26 system's enrollee no more than the lowest amount paid for that
27 service under the managed health care system's contracts with similar
28 providers in the state if the managed health care system has made
29 good faith efforts to contract with the nonparticipating provider.

30 (10) For services covered under this chapter to medical
31 assistance or medical care services enrollees and provided on or
32 after August 24, 2011, nonparticipating providers must accept as
33 payment in full the amount paid by the managed health care system
34 under subsection ((~~(7)~~)) (9) of this section in addition to any
35 deductible, coinsurance, or copayment that is due from the enrollee
36 for the service provided. An enrollee is not liable to any
37 nonparticipating provider for covered services, except for amounts
38 due for any deductible, coinsurance, or copayment under the terms and
39 conditions set forth in the managed health care system contract to
40 provide services under this section.

(11) Pursuant to federal managed care access standards, 42 C.F.R. Sec. 438, managed health care systems must maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the authority, including hospital-based physician services. The authority will monitor and periodically report on the proportion of services provided by contracted providers and nonparticipating providers, by county, for each managed health care system to ensure that managed health care systems are meeting network adequacy requirements. No later than January 1st of each year, the authority will review and report its findings to the appropriate policy and fiscal committees of the legislature for the preceding state fiscal year.

(12) Payments under RCW 74.60.130 are exempt from this section.

(13) Subsections (9) through (11) of this section expire July 1, ((~~2016~~)) 2021."

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On page 1, line 2 of the title, after "providers;" strike the remainder of the title and insert "and amending RCW 74.09.522."

EFFECT: Restores an expiration date, moved out to July 1, 2021.

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